

FILED MAY 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **16839**  
318 1003 Registrar's No. **3977**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> c. LENGTH OF STAY (in this place) <b>1 day</b> d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Baptist Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis</b> d. Is Residence within limits of a city (incorporated town)? Yes <input type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <b>6405a Arsenal St.,</b> 3 <b>2030</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Ernest</b> b. (Middle) <b>B.</b> c. (Last) <b>Menees</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1955</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Aug. 18, 1906</b>		9. AGE (In years last birthday) <b>48</b>		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Anna, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James A. Menees</b>		13b. MOTHER'S MAIDEN NAME <b>Ollie Hill</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah Gladys Menees</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Sarah Gladys Menees</b> ADDRESS <b>6405a Arsenal St.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of liver with wide spread metastases 2 mos.</b> ANTECEDENT CAUSES <b>Cirrhosis of liver 2 yrs</b> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>1561</b>			
22. I hereby certify that I attended the deceased from <b>18 July, 1953</b> to <b>3 MAY, 1955</b> , that I last saw the deceased alive on <b>3 MAY, 1955</b> and that death occurred at <b>7:00 P. M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Richard A. Jones MD</b>		23b. ADDRESS <b>3720 Washington</b>		23c. DATE SIGNED <b>4 MAY 55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>May 4, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Jonesboro, Illinois.</b>	
DATE REC'D BY LOCAL REG. <b>MAY 4 - 1955</b>		REGISTRAR'S SIGNATURE <b>Charles Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. Hoffmeister Colonial Mortuary 6164 Chippewa St., St. Louis, Mo</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 19 1962

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 267

P. O. Address 2814 S. Broadway

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F) to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.